

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1035

63-031407

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. Primary Registration District No. Registrar's No.

FILED SEP 3 1963

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>Macon</u>	
Length of stay in 1b <u>8 months</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Meth. Hosp. & Med. Center</u>		d. STREET ADDRESS (If outside, give location) <u>120 1/2 N. Rollins Street</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Hallie</u> Middle <u>W.</u> Last <u>Lauck</u>			4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-1891</u>	9. AGE (last birthday) <u>72</u>	10. IF UNDER 1 YEAR Months <u>3</u> Days <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Clerk</u>			11. BIRTHPLACE (City and state or country) <u>Macon, Missouri</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Lauck Market</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		

13a. FATHER'S NAME <u>R.L. Wright</u>	13b. MOTHER'S MAIDEN NAME <u>Annie Landree</u>	14. NAME OF HUSBAND OR WIFE <u>Edward Lauck</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>	16. SOCIAL SECURITY NO. <u>5</u>	17. INFORMANT <u>Cousin</u> Address <u>605 E. Hyde Park</u> <u>St. Joseph, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the pleural and abdominal cavities.</u> DUE TO (b) <u>Carcinoma of the right breast.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>3 yrs. 2 mos</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>10:40</u> a.m. <u>A.</u> Month, Day, Year <u>7/5/60</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Macon, Missouri</u>	

21. I attended the deceased from <u>7/5/60</u> to <u>8/23/63</u> and last saw her <u>alive</u> on <u>8/23/63</u> Death occurred at <u>10:40 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>John R. McDaniel, M.D.</u>	22b. ADDRESS <u>902 Edmund St. St. Joseph, Mo.</u>	22c. DATE SIGNED <u>8/26/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-23-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bram Funeral Home</u>	23d. LOCATION (City, town, or county) <u>Macon, Missouri</u>
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24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Funeral Home, Inc.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 29, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clara Handell</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

J.R.M. Daniel, M.D.

Permit issued 8-28-63

File
1100

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STATEMENT BY LICENSED EMBALMER

6-2

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Lee J. Chaney

Licensed Embalmer No. 4679

P. O. Address 57 Osage, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.